

SC Public Employee Benefit Authority
South Carolina Retirement Systems
Member's Disability Report

(please complete all sections)
To be completed by member or legal representative

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Section I

PERSONAL INFORMATION

1. Last Name & Suffix <u>Nelson</u>	2. First/Middle Name <u>Selena Duchette</u>	3. Social Security Number <u>247-71-0606</u>
4. Date of Birth <u>02/13/1978</u>	5. Address <u>6202 N. Okatie Hwy</u>	6. Phone <u>252-936-9898</u>
7. City <u>Ridgeland</u>	8. State <u>SC</u>	9. ZIP+4 <u>29936-9898</u>

Section II

- a) Describe your disability: I am confined to a permanent right knee brace for stability. My right knee is swollen, painful, weak, locks and constantly gives out on me, whereas I fall. I do not have full use of my right leg due to this disability issue.
- b) When did your disability prevent you from working? Month 10 Day 30 Year 2018
- c) Explain why you stopped working: I can no longer wear the protected gear, boots provided by law enforcement to fully do my job for the past 14 1/2 years. My right knee condition is worse, whereas it is unsafe to do my duties. I cannot sit for a period of time due to locking up, pain, swollen and limited range of motion. I have implants / NO meniscus. I am confined to a brace fulltime.
- d) Have you returned to work? ☐ Yes ☒ No If yes, when _____
- e) Have you applied for Social Security Disability benefits? ☐ Yes ☒ No If yes, when _____
- f) Has your disability resulted from an on the job injury? ☒ Yes ☐ No If yes, when Started 2009 from the Beaufort County Sheriff's Office
- g) Have you filed a Workers Compensation claim? ☒ Yes ☐ No If yes, when In the past year of 2010 thru 2012

Section III

A) Please list the names, addresses, and telephone numbers of physicians who have your current medical records. Or, submit any current medical records you have with this Disability Report. If further medical evidence develops while your claim is being evaluated, please forward the documentation to the SCRS Medical Board.

1. Physician's name: Joseph Tobin M.D.
Address: 12 Lafayette Place, Hilton Head Island South Carolina 29926
Telephone: (843) 342-9100
How often did you see this physician? Between 1 to 2 times a month
Date first seen: 11/1/2016 Date last seen: 10/30/2018 still going (current)
Treatment Received: Steroid injections, Euflexxa Injections x3, pain managements and medications MRI, X-RAYS and will be going through another right knee surgery
2. Physician's name: DR. George Sutherland
Address: 16 Okatie Center Blvd S. Okatie SC 29909
Telephone: (843) 705-9401
How often did you see this physician? 2010 through 2013
Date first seen: _____ Date last seen: _____
Treatment Received: Multiple Surgeries

3. Physician's name: _____

Address: _____

Telephone: _____

How often did you see this physician? _____

Date first seen: _____

Date last seen: _____

Treatment Received: _____

B) Have you been treated at a hospital or clinic for your disability? ☐ Yes ☒ No If yes, complete the following:

1. Name and Address: _____

☐ Inpatient: If yes, give dates of admission and dates of discharge.

☐ Outpatient: If yes, give date of admission

_____ to _____

_____ to _____

Reason for admission: _____

Type of treatment received: _____

2. Name and Address: _____

☐ Inpatient: If yes, give dates of admission and dates of discharge.

☐ Outpatient: If yes, give date of admission

_____ to _____

_____ to _____

Reason for admission: _____

Type of treatment received: _____

3. Name and Address: _____

☐ Inpatient: If yes, give dates of admission and dates of discharge.

☐ Outpatient: If yes, give date of admission

_____ to _____

_____ to _____

Reason for admission: _____

Type of treatment received: _____

4. Name and Address: _____

☐ Inpatient: If yes, give dates of admission and dates of discharge.

☐ Outpatient: If yes, give date of admission

_____ to _____

_____ to _____

Reason for admission: _____

Type of treatment received: _____

C) Have you been evaluated by other agencies for your disability? ☒ Yes ☐ No (for example, Veterans Administration)

Workers Compensation, Vocational Rehabilitation, Social Security Administration)

If yes, name of agency: Ariel TPA Worker's Compensation

Address: P.O. Box 212159 Columbia SC 29021

Your claim number with this Agency: _____ See documents

Dates of visits: Started in 2009 through 2013

Type of treatment or examinations received: Multiple Surgeries to include staying at Coastal Carolina Hospital for Surgery to right Knee, Mobilization, Physical therapy for approx. 3 years, Disability rating in 2012 in right Knee, which condition has gotten worse, EVERY day Swollen, PAIN, Numbness, locking, giving out, unstable.

D) If you have additional medical information to support your disability, please attach a separate sheet listing information required above.

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Section IV

Has your doctor restricted your work activities in any way? ☒ Yes ☐ No

If yes, which doctor? Dr. Joseph Tobin

State what the physician told you not to do: NO WORK - Right Knee is bad and dis

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Section V

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Has your disability restricted your activities of daily living such as: home duties, social activities, or your ability to care for your personal needs? ☒ Yes ☐ No

If yes, please describe your limitations: I moved back home with family because I am unable to stand for a period of time. I am unable to maintain balance without my knee giving out. I am unable to do any chores. My mom makes my meals and assist me in the tub. I can not attend any social events due to not maintaining balance on right leg. I can not shop for myself. I sit or lay down majority of the day due to my right knee. I have to take pain and sleep medication for comfort everyday. Loss of appetite and suffers from POST TRAUMATIC STRESS DISORDER. I take Wellbutrin (High Dose) Clonazepam and Zolpidem.

Section VI

a) What was your most recent job(s) before you stopped working? If you have more than one job, please list separately.

Job Title: Police Officer

Employer: Town of Bluffton Police Department

From: 9/5/2017

to: 10/26/2018

b) In this job did you:

Beaufort County Sheriff Office / Deputy Sheriff March 15, 2014 to Aug 10, 2017

1. Use machines, tools, or equipment of any kind? ☒ Yes ☐ No

If yes describe type of tools/equipment used: Duty WAIST Belt weighs approx. 60 lbs, wearing heavy Boots Since March 2004 to Oct. 23, 2018,

2. Use technical knowledge or skills? ☒ Yes ☐ No

If yes, describe technical knowledge or skills: Protecting and serving the public, running, jumping, driving, sitting for typing, Agility training, Fire arm Training

3. Do any writing, complete reports, or perform similar duties? ☒ Yes ☐ No

If yes, please describe: Report writing, PHEC Reports, Collision Reports, animal Reports and DEATH Notification Forms.

4. Have supervisory responsibility? ☒ Yes ☐ No

If yes, please indicate the number of employees supervised and the extent of your supervision:

For approx. a year at the Beaufort County Sheriff's Office I supervised approx. 8 people on a shift in 2016 to the beginning of May 2017.

c) Please describe your essential job duties:

As a Law Enforcement officer duties requires protecting and serving the public, Protection of People and property, conducting traffic stop, working collisions, walking, running or chasing criminals, stairs climbing, operating company vehicle, dealing with animals and alligators, Crowd and Traffic Control, dealing with Mental Illnesses, Work 12 HOUR ROTATING SHIFT 9 DAYS AND NIGHTS. I walk with a permanent limp (right leg) Working throughout the years after my injuries has really ruined my ability to use my right leg, stability and comfort zone. I walk with a permanent limp.

d) Describe the amount of physical activity your job involves during a typical work day.

WALKING (check number of hours a day) 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☒

STANDING (check number of hours a day) 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☒

SITTING (check number of hours a day) 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☒

BENDING / STOOPING (check number of hours per day) 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☒ 7 ☐ 8 ☐

CLIMBING (check number of hours per day) 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☒

RUNNING (check number of hours per day) 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☒

LIFTING AND CARRYING:

OCCASIONALLY (UP TO 1/3 OF AN 8-HOUR DAY) LIFTS AND/OR CARRIES:

<input type="checkbox"/> LESS THAN 10 LBS.	Kinds of objects lifted:	<u>Sometimes I just stay in bed clothing</u>
<input type="checkbox"/> 10 LBS.	Kinds of objects lifted:	<u>NO</u>
<input type="checkbox"/> 20 LBS.	Kinds of objects lifted:	<u>CAN NOT DO</u>
<input type="checkbox"/> 50 LBS.	Kinds of objects lifted:	<u>CAN NOT DO</u>
<input type="checkbox"/> 100 LBS. OR MORE	Kinds of objects lifted:	<u>CAN NOT DO</u>

FREQUENTLY (1/3 TO 2/3 OF AN 8-HOUR DAY) LIFTS AND/OR CARRIES:

<input type="checkbox"/> LESS THAN 10 LBS.	Kinds of objects lifted:	<u>Sometimes to nurse I DO NOT DO MUCH ANY MORE TOO PAINFUL</u>
<input type="checkbox"/> 10 LBS.	Kinds of objects lifted:	<u>NO</u>
<input type="checkbox"/> 25 LBS.	Kinds of objects lifted:	<u>CAN NOT DO</u>
<input type="checkbox"/> 50 LBS. OR MORE	Kinds of objects lifted:	<u>CAN NOT DO</u>

Section VII

Remarks: This section may be used for additional information that will be helpful to make a decision about your disability claim:

DUE TO my right knee injuries I am unable to perform my job or anything. My knee is swollen, painful, locks, give away, unstable. Every day, I am confined to a permanent brace. If I do not wear the brace I lose balance and fall. When I was still working since my injuries to my knee I fell on the job several times running. My right leg has gotten weaker and I have limited range of motion. I can not bend my knee anymore. I worked with a swollen and painful knee after my injuries because I did not want to give up. Now it is unsafe to where I'm falling and my knee is weak along with my leg. In 2012 I was rated disabled. Now I can not do anything like before. I suffer from PTSD, caused by being in Law Enforcement. I have a permanent limp. It is hard for me to stay balanced, I will be going for another surgery with Dr. Tobin.

The information I have provided is correct to the best of my knowledge.

Signature of Applicant: Delana D. Nelson

Date: 10/30/2018

(If signed by other than the applicant, a copy of the Power of Attorney for the person signing must be attached)

Return to:
SC Public Employee Benefit Authority
South Carolina Retirement Systems
Customer Annuity Claims
PO Box 11960, Columbia SC 29211-1960

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